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FILED
AUG 22 1958
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No. 205

In the Supreme Court of the United States

OCTOBER TERM, 1958

HELEN M. KIEFER, PETITIONER

v.

UNITED STATES OF AMERICA

On Petition for a Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF FOR THE UNITED STATES IN OPPOSITION

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OPINION BELOW

The United States District Court for the District of Columbia entered no opinion. The opinion of the United States Court of Appeals for the District of Columbia Circuit on the first appeal in this case is reported at 228 F. 2d 448, and certiorari was denied by this Court at 350 U.S. 933. The opinion on the second appeal (Pet. 13-14) is reported at 255 F. 2d 189.

JURISDICTION

The judgment of the Court of Appeals affirming the judgment of the District Court was entered May 8, 1958 (Pet. 15). The petition for a writ of certiorari was filed July 23, 1958. The jurisdiction of this Court is presumably invoked under 28 U.S.C. 1254.

QUESTION PRESENTED

Whether both courts below were correct in holding that the United States had established that the insured obtained reinstatement of his policy of National Service Life Insurance by fraud.

STATUTE AND REGULATIONS INVOLVED

In pertinent part, the National Service Life Insurance Act of 1940 (38 U.S.C. 801, *et seq.*) provides as follows (as it appears in the United States Code):

Section 802.

* * * *

(w) *Incontestability of policies.*

Subject to the provisions of section 812 of this title, all contracts or policies of insurance before or after August 1, 1946, issued, reinstated, or converted shall be incontestable from the date of issue, reinstatement, or conversion except for fraud, nonpayment of premium, or on the ground that the applicant was not a member of the military or naval forces of the United States.

* * * *

Section 808. *General administrative provisions.*

The Administrator, subject to the general direction of the President, shall administer, execute, and enforce the provisions of this subchapter, shall have power to make such rules and regulations, not inconsistent with the provisions of this subchapter, as are necessary or appropriate to carry out its purposes, and shall decide all questions arising hereunder. * * *

Veterans Administration Regulation 3423 (12 F.R. 7116 (1947)), as amended (13 F.R. 181 (1948)), and 3424 (38 C.F.R. (1946 Supp.) Section 10.3424),

as amended (13 F.R. 657 (1948)), provide in pertinent part as follows:

> Section 10.3423—*Health Requirements:* National Service Life Insurance or any plan may be reinstated if application and tender of premiums are made:
>
> (a) On or before July 31, 1948, or within three months after lapse, whichever is later, provided the applicant be in as good health on the date of application and tender of premiums as he was on the due date of the premium in default and furnishes evidence thereof satisfactory to the Administrator.
>
> (b) Subsequent to July 31, 1948, and after expiration of the three-month period mentioned in paragraph (a) of this section, provided applicant is in good health (§ 10.3401) on the date of application and tender of premiums, and furnishes evidence thereof satisfactory to the Administrator of Veterans' Affairs.
>
> Section 10.3424—*Application and medical evidence* * * * Applicant's own statement of comparative health may be accepted as proof of insurability for the purpose of reinstatement under § 10.3423(a), but, whenever deemed necessary in any such case by the Administrator, report of physical examination may be required. * * *

STATEMENT

Petitioner sued, as sole beneficiary, for benefits under her deceased brother's National Service Life Insurance policy (I J.A. 2).[1] The Government con-

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[1] References (I J.A. ——) are to the joint appendix in the Court of Appeals on the first appeal in this case and references (II J.A. ——) are to the joint appendix on the second

tested the policy on the ground of fraud, alleging that the insured's policy had been reinstated in 1948 in reliance upon an application which falsely represented his comparative health (I J.A. 13-14). The insured had answered questions 8, 9, and 10 of this application as follows (I J.A. 16-17):

> 8. Are you now in as good health as you were on the due date of the first premium in default? [x] Yes [ ] No.
>
> 9. Have you been ill, or suffered or contracted any disease, injury, or infirmity, or been prevented by reason thereof from attending your usual occupation, or consulted a physician, surgeon, or other practitioner for medical advice or treatment at home, hospital, or elsewhere, in regard to your health, since lapse of this insurance? [ ] Yes [x] No. (If "Yes," give all dates and full particulars below.).
>
> 10. Have you ever applied for disability compensation, retirement pay, pension or waiver of insurance premiums? [x] Yes [ ] No. (If "yes," give Claim No. below.) C-No. 5 241 066.

The insured's disability claim file, the number of which he listed in answer to question 10, indicated that he had been discharged from the Army in 1945 on a certificate of disability for bronchial asthma, and was granted a 60 percent disability compensation, for which a claim number was assigned (I J.A. 11). The file showed that from August 1945 through February 13, 1948, the insured had received occa-

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appeal; both form part of the record in this Court, either on this Petition or on the Petition in No. 518, October Term, 1955. (Cf. *United States* v. *Pink*, 315 U.S. 203, 216.

sional treatment and hospitalization for chronic bronchial asthma and certain minor conditions, including mild hypertension and nephritis (I J.A. 11-12, 18-37). On March 16, 1948, he was recommended for emergency hospitalization by Dr. Norman E. Marsh, Veterans Administration consulting physician, who reported as follows (I J.A. 39):

> **Brief History:** Prostration, abdominal distension, nausea and vomiting. Has consumed large quantities of liquor during last 6 mos.
> Physical Findings: Extreme enlargement of liver.
> **Diagnosis:** Prob. Cirrhosis of liver.

The insured was thereupon immediately admitted to the United States Naval Hospital, Corona, California, where the diagnosis of cirrhosis of the liver was confirmed, with the notation that the patient had been "drinking steadily for 6 months about a quart a day. His liver is down to his iliac crest. He has been nauseated and vomiting for some time. No food for 36 hours." (I J.A. 40-44). This emergency hospitalization, which lasted nearly a month, occurred immediately prior to the reinstatement application in April 1948, in which the insured represented that his comparative health had not changed since the date of lapse and that he had not been ill nor consulted a physician at home or at a hospital during the period of lapse.

In November 1951, the insured was again examined for emergency hospitalization, and admitted to the Veterans Administration Hospital, Long Beach, California, where he died on November 20, 1951. The

final diagnosis was "1. Metabolic alkalosis, prerenal azotemia due to prolonged vomiting, cause unknown but probably due to acute alcoholism. 2. Cirrhosis of the liver" (I J.A. 52-54).

Subsequent to the death of the insured, the Veterans Administration assembled all of his records in order to determine what death benefits were payable to his account. At this time his insurance records, which had previously been in the files of the Insurance Service, and his compensation records, always in the files of the Compensation Service, were for the first time brought together and compared, and the discrepancy with respect to comparative health discovered. Upon the refusal of the Veterans Administration to pay on the policy, petitioner brought this action.

The District Court initially awarded summary judgment to petitioner, ruling that the insured, by disclosing his "C" number in answer to question number 10 on the application for reinstatement (*supra*, p. 4), precluded the Government as a matter of law from claiming reliance on the false representations (I J.A. 13-14). The Court of Appeals for the District of Columbia Circuit reversed, holding that there was no evidence that the Insurance Service ever had actual knowledge of the contents of the insured's disability compensation file, and that in the circumstances of this case it could not be charged with constructive knowledge thereof. *United States* v. *Kiefer*, 228 F. 2d 448. Concluding that the District Court had erred in its view of the applicable law with respect to the element of reliance, the Court of Appeals re-

manded the case for trial in order to determine whether all of the elements of fraud were in fact present (228 F. 2d at 452). The petitioner sought review of that issue in this Court, but her petition for a writ of certiorari was denied (350 U.S. 933).

A jury trial was held in the District Court on March 13 and 14, 1957. The medical evidence referred to above was introduced into evidence, and the depositions of three doctors who had attended the insured during the period prior to the second reinstatement of his insurance were read by Government counsel (II J.A. 21-58). None of these doctors had any independent recollection of the insured, and their testimony was therefore confined to a discussion of the material in their records and the answering of hypothetical questions. In addition, the Director of Medical Service of the Veterans Administration and a Technical Advisor, Department of Insurance, Veterans Administration, testified for the Government (II J.A. 58, 82). Petitioner's only witness was one Thomas E. Carter, a section chief in the Veterans Claims Division of the Veterans Benefits Office, who appeared in response to a subpoena served upon the Administrator of Veterans Affairs, and testified as to the procedures followed in handling veterans' claims (II J.A. 101). Petitioner offered in evidence the insured's death certificate, which was received as Plaintiff's Exhibit No. 1 for the limited purpose of proving the death of the insured (II J.A. 104). The court refused, however, to receive this exhibit for the purpose of proving how long the insured had suffered from

cirrhosis of the liver, and likewise excluded Plaintiff's Exhibits 2 through 6, which related to medical treatment given the insured subsequent to the date of his April, 1948 application for reinstatement. (II J.A. 104, 109, 110). At the conclusion of the evidence, both parties moved for directed verdicts (II J.A. 111). The District Court granted the Government's motion, and verdict and judgment were entered for the United States (II J.A. 111).

On appeal, the same panel of the Court of Appeals that had heard the earlier appeal in this case, held, in a *per curiam* decision (Pet. 13-14), that "the record fully supports" the action of the District Court in granting the motion of the United States for a directed verdict, and accordingly affirmed the judgment.

ARGUMENT

This case presents no occasion for review by this Court. The disposition in the courts below turned upon the particular facts of this case, and, as we shall show, the uncontroverted evidence left the District Court with no alternative but to direct a verdict for the United States. Petitioner's allegations of a conflict of decisions are meritless; the only significant legal question in this case—whether the Government was precluded as a matter of law from relying upon the insured's deliberate misrepresentations—was disposed of on the first appeal of the case, and further review was properly denied by this Court. That decision was fully in accord with decisions of the Fifth, Sixth and Seventh Circuits, and its rationale has since been expressly adopted by the Second and Ninth

Circuits. Petitioner's other contentions are equally without merit, and raise no issues for this Court's consideration.

1/ The uncontradicted facts before the District Court clearly established each of the essential elements of fraud in the reinstatement of the insured's policy of National Service Life Insurance—" * * * (1) a false representation (2) in reference to a material fact (3) made with knowledge of its falsity (4) and with the intent to deceive (5) with action taken in reliance upon the representation." *Pence* v. *United States*, 316 U.S. 332, 338. Petitioner failed to produce a scintilla of evidence to rebut this clear showing and accordingly, as in the *Pence* case, the District Court properly directed a verdict for the United States.[2]

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[2] The question of the propriety of a directed verdict on the issue of fraud depends, of course, upon the circumstances of the particular case. As we shall show, *infra*, pp. 10-14, the uncontroverted evidence here plainly required a directed verdict for the United States; accordingly the two decisions which petitioner cites for the proposition that the issue of fraud here was for the jury—*Jones* v. *United States*, 112 F. 2d 282 (C.A. 8) and *Bailey* v. *United States*, 92 F. 2d 456 (C.A. 5)—are plainly inapposite. Thus, in the *Jones* case, unlike the present situation, there was a clear conflict of evidence which presented controverted issues of fact. The court there stated (112 F. 2d at 286):

> There was a sharp conflict in the substantial evidence on each side relative to the state of health of the insured at the time of the reinstatement of the policies and as to his knowledge thereof at such time. Therefore the case should have been submitted to the jury for determination.

The *Bailey* case is likewise distinguishable, in that the district court in that case had erroneously held that false state-

a. The insured's medical history conclusively demonstrates the falsity of his representations of comparative health. Despite his statements in his application of April 26, 1958, that he was then in as good health as he was on the due date of the first premium in default (here September, 1947), and had not been ill or received medical treatment since that date, the records show that from March 16, 1948 to April 9, 1948 the insured had received emergency hospitalization for cirrhosis of the liver, a serious ailment and one not previously mentioned in his medical history. The medical experts testified at the trial that the insured "was considerably ill at that time" (II J.A. 51, 52), and "seriously in need of hospitalization or at least medical treatment" (II J.A. 63). Thus, his representations in his application were demonstrably false.

b. These representations are clearly material, dealing as they do with the applicant's health and providing the sole basis for reinstatement of his insurance. The very purpose of the question was, of course, to elicit material information, *United States* v. *Dopear*, 100 F. 2d 725 (C.A. 10); the health of the appli-

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ments were fraudulent irrespective of whether the applicant knew of their falsity or intended to deceive. The Court of Appeals for the Fifth Circuit held that, in the circumstances of that case, these issues, as well as the question of the falsity of the representations, were for the jury. The Fifth Circuit has since expressly held that a directed verdict is proper in a case which was in every material respect identical with the present one. *McDaniel* v. *United States*, 196 F. 2d 291 (C.A. 5). See also *Danaher* v. *United States*, 181 F. 2d 673 (C.A. 8).

cant is of vital importance to the insurer, and representations as to consultations with physicians or treatment for serious ailments are held to be material as a matter of law. *United States* v. *Dopew*, *supra*; *Dunahoe* v. *United States*, 181 F. 2d 673 (C.A. 8); *Raines* v. *Raines*, 54 F. 2d 267 (C.A. 2); *Halverson* v. *United States*, 121 F. 2d 420 (C.A. 7), certiorari denied, 314 U.S. 695; cf. *Penn* v. *United States*, 316 U.S. 332, 339. Particularly is this true where, as here, reinstatement of the applicant's insurance was made without a physical examination, and solely on the basis of his own statements as to his comparative health.

c. The applicant obviously knew he was answering these questions falsely. The information requested was necessarily within his own knowledge, and there is "no room for doubt" that he was aware of the falsity of his answers. *United States* v. *Elliott*, 73 F. 2d 374 (C.A. 5), certiorari denied, 295 U.S. 740. Thus, despite his disclaimer of medical treatment, his medical history discloses, not merely casual physical examinations or medical consultations, but emergency hospitalization for a period of more than

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[3] In any event, false representations are material if, had the true facts been disclosed, they would be regarded as substantially increasing the chance of loss, or if a careful insurer would have refused reinstatement or would have made a further study of the risk involved. *Mutual Life Ins. Co. of New York* v. *Hurni Packing Co.*, 260 Fed. 641 (C.A. 8), certiorari denied, 251 U.S. 556; *Fountain & Harrington, Inc.* v. *Mutual Life Ins. Co.*, 55 F. 2d 120 (C.A. 1); *Ginsburg* v. *Pacific Mutual Life Ins. Co.*, 89 F. 2d 158 (C.A. 2), certiorari denied, 302 U.S. 708.

three weeks, just a short time prior to the filing of his application for reinstatement. Nor could the applicant have failed to know that he was ill. He had been brought to the hospital by ambulance as an emergency patient suffering from "prostration, abdominal distension, nausea and vomiting" (I J.A. 39, 40-44). The committing physician, Dr. Marsh, stated that as a result of the insured's symptoms "he should realize that he was a pretty sick man" (II J.A. 33). It is inconceivable that only three weeks later the insured could have forgotten this extended hospitalization and these severe symptoms. To the contrary, the only possible conclusion is that he knew he was answering questions 8 and 9 falsely. *Danaher* v. *United States*, 181 F. 2d 673, 676 (C.A. 8); *McDaniel* v. *United States*, 196 F. 2d 291 (C.A. 5); *Meadors* v. *United States*, 118 F. Supp. 277 (E.D. Ky.), affirmed, 219 F. 2d 438 (C.A. 6). And, of course, since the insured knowingly made false answers to material questions in his application for reinstatement, the requisite intent to defraud is presumed as a matter of law; there is no necessity for further proof of actual conscious design to deceive. *Kavakos* v. *Equitable Life Assur. Soc.*, 88 F. 2d 762 (C.A.D.C.), and cases cited therein; *Claflin* v. *Commonwealth Ins. Co.*, 110 U.S. 81; *Mutual Life Ins. Co.* v. *Hilton-Green*, 241 U.S. 613; *Pence* v. *United States*, 316 U.S. 332; *Raives* v. *Raives*, 51 F. 2d 267 (C.A. 2); *Nowantony Ins. Co.* v. *Maryland Casualty Co.*, 56 F. 2d 329 (C.A. 1); *Lytle* v. *Pacific Mut. Life Ins. Co.*, 72 F. 2d 140 (C.A. 6); *Columbian*

Nat. Life Ins. Co. v. *Rodgers*, 93 F. 2d 740 (C.A. 10).[1]

d. Finally, there is no question but that the Veterans Administration in fact relied upon the insured's representations in reinstating his insurance. The applicable regulations provided that an applicant's "own statement of comparative health may be accepted as proof of insurability for the purpose of reinstatement" (38 C.F.R. 8.24), and it is indisputable that the Veterans Administration in fact accepted the insured's representations at their face value and without further investigation reinstated his insurance. See testimony of Edgar J. Mason (II J.A. 82-91). Indeed, an insurer is presumed as a matter of law to have relied upon the truthfulness of material representations. *United States* v. *Dopar*, 100 F. 2d 725 (C.A. 10); *Daugher* v. *United States*, 184 F. 2d 673 (C.A. 8); see *Columbian Nat'l Life Ins. Co.* v. *Rodgers*, 93 F. 2d 740 (C.A. 10); cf. *Ponce* v. *United*

[1] Contrary to petitioner's contention, the insured's listing of his C-Number in answer to question 10 in no way demonstrates that his answers to questions 8 and 9 were not wilfully false or were made without intent to deceive. For the insured's C-Number referred only to his disability compensation claim for bronchial asthma, an ailment which was completely unrelated to his liver condition (see, *e.g.*, testimony of Dr. Mueller, II J.A. 58-62), and he had no reason whatever to assume that information as to the latter illness would find its way into his C-file. Moreover, as the Fifth Circuit held in rejecting precisely this argument "no amount of casuistry short of that which would make black seem white, the false true, can explain away or justify the false answers the insured deliberately gave". *McDaniel* v. *United States*, 196 F. 2d 291, 294 (C.A. 5).

States, 316 U.S. 332. As this Court said in *Claflin* v. *Commonwealth Ins. Co.*, 110 U.S. 81, 95: "[T]he law presumes every man to intend the natural consequences of his acts. No one can be permitted to say, in respect to his own statements upon a material matter, that he did not expect to be believed".

2. Petitioner's other contentions are obviously without merit, and raise no issue for this Court's review.

a. Although petitioner does not challenge the fact that this insurance was reinstated in reliance upon the insured's answers to questions 8 and 9 in the application, she nevertheless attempts to reargue the issue involved in the previous appeal in this case, claiming that since the insured listed his C-Number on his application, and his C-file contained information demonstrating the falsity of these representations, the Insurance Service of the Veterans Administration was precluded as a matter of law from relying upon them. This question was carefully examined by the Court of Appeals for the District of Columbia Circuit in the first appeal in this case, 228 F. 2d 448, certiorari denied, 350 U.S. 933, and squarely resolved against petitioner. As we demonstrated in our Brief in Opposition to the Petition for a Writ of Certiorari on this question (No. 518, October Term, 1955), that decision was clearly correct and fully in accord with the applicable decisions. See, *e.g.*, *McDaniel* v. *United States*, 196 F. 2d 291 (C.A. 5); *United States* v. *Cooper*, 200 F. 2d 954 (C.A. 6); *Clohesy* v. *United States*, 199 F. 2d 475 (C.A. 7); *Halverson* v. *United States*, 121 F. 2d 420 (C.A. 7), certiorari denied, 314 U.S. 695; *Jones* v.

United States, 106 F. 2d 888 (C.A. 5); *Brown* v. *United States*, 102 F. Supp. 132 (W.D. Mo.); *Clarke* v. *United States*, 102 F. Supp. 338 (E.D. Mo.); cf. *United States* v. *Depew*, 100 F. 2d 725 (C.A. 10); *United States* v. *Riggins*, 65 F. 2d 750 (C.A. 9). Moreover, since that time, this decision of the District of Columbia Court of Appeals has been expressly adopted by the Courts of Appeals for the Second and Ninth Circuits in *United States* v. *Nero*, 248 F. 2d 16 (C.A. 2), and *United States* v. *Willoughby*, 250 F. 2d 524 (C.A. 9).[5]

b. Equally without substance is petitioner's contention (Pet. 7) that the insured was entitled to reinstatement of his policy of National Service Life Insurance under the provisions of 38 U.S.C. 802 (c)(2), which states *inter alia*, that the Administrator shall not deny, for the purposes of such reinstatement, "that the applicant is in good health because of any disability or disabilities, less than total in degree, resulting from or aggravated by such active service." In the first place, the ill health which the insured concealed was not a disability "resulting from or aggravated by" his active service; to the contrary, the record makes clear that the symptoms he failed to report were those of cirrhosis of the liver, apparently the result of prolonged drinking, and clearly in no way related to his service-

[5] The *Willoughby* decision "easily distinguished" *United States* v. *Kelley*, 136 F. 2d 823 (C.A. 9), the case upon which petitioner primarily relied in seeking certiorari in No. 518, and in urging further review of the issue here. 250 F. 2d at 531-532.

connected bronchial asthma. Moreover, even if the insured's illness was service-connected or service-aggravated, he could not obtain reinstatement under Section 802(c)(2) unless an application based on the grounds set forth in that Section had been presented to and passed upon by the Administrator of Veterans Affairs. See, *e.g.*, *United States* v. *Nero*, 248 F. 2d 16 (C.A. 2); cf. *United States* v. *Cooper*, 200 F. 2d 954 (C.A. 6); *Jones* v. *United States*, 106 F. 2d 888 (C.A. 5). The insured, however, applied for reinstatement[7] on a comparative health basis, and it was on these terms that the Administrator processed the application and approved reinstatement of the policy. Plainly this application cannot now form the basis of a claim of entitlement to reinstatement under Section 802(c)(2).[6]

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[6] The Court of Appeals in the *Nero* case rejected precisely this contention, stating (248 F. 2d at 18):

> The Administrator determined that Nero was eligible for reinstatement under § 802(y), and since the Administrator has never taken any action with respect to whether Nero was entitled to reinstatement under § 802(c)(2), the decision of the trial court that reinstatment was mandatory under 802(c)(2) was error. *Scott* v. *United States*, 189 F. 2d 863 (5 Cir. 1951). An application for one type of reinstatement cannot be treated by the District Court as an application for another type of reinstatement. Cf. *United States* v. *Cooper*, 200 F. 2d 954 (6 Cir. 1953); *Jones* v. *United States*, 106 F. 2d 888 (5 Cir. 1939).

[7] Section 802(y), providing for reinstatement on a comparative health basis, was repealed in 1917 (61 Stat. 6) but similar provisions were promulgated in the Administrator's regulations, *supra*, p. 3, upon which the insured's application here was based.

c. Finally, petitioner asserts as error the refusal of the district court to admit evidence as to the health of the insured subsequent to the date of his fraudulent misrepresentations in his application for reinstatement. It is perfectly clear, however, that this evidence is completely immaterial to the question at issue, *i.e.*, the intent of the insured at the time he submitted his application for reinstatement, and that it was therefore properly excluded.

CONCLUSION

For the foregoing reasons we respectfully submit that the petition for a writ of certiorari should be denied.

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AUGUST, 1958.

U. S. GOVERNMENT PRINTING OFFICE 1958 478602 185